CORRESPONDENCE

- *All letters must be typed with double spacing and signed by all authors.*
- *No letter should be more than 400 words.*
- *For letters on scientific subjects we normally reserve our correspondence columns for those relating to issues discussed recently (within six weeks) in the BMJ.*
- *We do not routinely acknowledge letters. Please send a stamped addressed envelope if you would like an acknowledgment.*
- *Because we receive many more letters than we can publish we may shorten those we do print, particularly when we receive several on the same subject.*

Chief inspector criticises prison medical service

SIR,—Dr Richard Smith reported a critical account of the prison medical services by the chief inspector of prisons and his medical inspector.[1] As there has been no response we, as experienced members of the board of visitors of Lincoln Prison, would like to present a different picture. Our findings are the result of a detailed series of interviews with staff and inmates and apply only to Lincoln, a prison that daily receives newly convicted and remand prisoners in large numbers.

The chief inspector writes of bored doctors who see only six or seven patients a day—and that "Many full time prison doctors seldom see prisoners on reception or do sick parades or night calls" and "In many prisons it was only a determined inmate who got to see the doctor."

In Lincoln the treatment room opens at 0730. Patients present themselves with no difficulty. Random inmates were asked about reporting sick, and all said that they went to the treatment room with no hint of any hindrance. A daily sick parade is carried out by the doctor at 0815. A full rota is maintained by one part time and two full time doctors. A consultant venereologist and dermatologist attend weekly, and two consultant psychiatrists attend two or three times a week.

All inmates are seen on arrival by a doctor for a brief medical review of any ailments or current drug treatment and, most important of all, to detect potential suicide at possibly the most stressful point in a newly convicted prisoner's life. On the evening of our visit the doctor saw 41 admissions, starting at 1800, with the intention of getting them settled in cells by 1930. The chief inspector reported that "routine testing of blood pressure or urine on admission is unusual." Clearly, with the constraints on time, the large flow of entrants to a local prison precludes routine testing. In addition, how cost effective is it to test routinely a group of mainly young men for conditions for which a new diagnosis is unlikely to be made? Inmates presenting with, say, hypertension or diabetes are tested and checked. Treatment is reviewed. A detailed medical on entrance to a local prison is neither necessary nor practicable. Prevention of suicide must surely be the priority.

Criticisms are made of doctors' failure to campaign for improved standards of hygiene and cleanliness. The bathing facilities and changes of underclothing in Lincoln will, by the end of November, compare favourably with those in civilian life. The myth of inmates being locked in cells for 20 hours daily is simply not true at Lincoln.

Hospital officers are reported to "filter out" patients. This is an acceptable procedure in general practice, when the nurse will often be a patient's first contact; why not in prison? Inmates can be a highly manipulative group, and it would be impossible to respond instantly to every demand for instant medical attention throughout the day and night.

The medical inspector writes, "A number of doctors in full time medical service would not be able to maintain a job outside." In a letter to the *BMJ* from the Home Office two weeks later it transpired that none of these doctors is still working in the prison service.[2] If this is so why denigrate colleagues in the first place?

The medical and nursing team has introduced courses of counselling for sex offenders, alcoholics, and drug addicts. A new system of management has been introduced in the prison hospital, and soon an experiment unique in the prison service will begin, wherein inmates will sit in on the management conferences of the hospital staff.

We do not pretend that there are no faults in Britain's prison services, but we wish to emphasise that with good management and leadership from governors, prison officers, and the medical and nursing team a humane and efficient service can result from existing resources. The blanket condemnations quoted in your article can only undermine the morale of prison staff of all grades who do an exceptional and difficult job.

J R SAVAGE
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1 Smith R. Chief inspector criticises prison medical service. *BMJ* 1990;**301**:253. (4 August.)
2 Wool RJ. Chief inspector criticises prison medical service. *BMJ* 1990;**301**:388. (18-25 August.)

Bedding and sleeping position in the sudden infant death syndrome

SIR,—Drs Warren G Gunteroth and Phillip S Spiers[1] suggest that our results[2] were likely to have been influenced by bias in the parents' recall and by parents wishing to conform to the norms of society. For reasons given in our previous letter we do not believe there was selective recall, and the home visit by one of our team, which amounted to a "death scene" inquiry, allowed us to verify the information in many instances.

The suggestion that the sudden infant death syndrome is most common in the sleeping position most commonly adopted in each society is at considerable variance with the published reports we have reviewed. In particular, the study by Lee *et al* from Hong Kong, where few babies are nursed prone, confirmed the increased risk associated with this position.[3] In another study few babies in either the sudden infant death syndrome or control group were nursed prone but a considerable excess of babies were nursed in the supine position in the control group.[4] The table summarises the results of these and other published controlled studies. We are aware of no published controlled studies that show that the supine position is associated with a higher risk of sudden infant death than the prone position.

Risk of sudden infant death associated with sleeping position found in different studies

Study	Sleeping position	Relative risk[5]	p Value
Beal[6]	Prone	9·32	<0·01
Cameron and Williams[6]	Prone	3·22	<0·01
Senecal *et al*[6]	Prone	12·5	<0·01
Lee *et al*[3]	Prone	11·7	<0·01
Nicholl and O'Cathain[6]	Prone	2·2	<0·01
McGlashan[5]	Prone	1·9	<0·01
Jonge *et al*[7]	Prone	3·4	<0·01
Fleming *et al*[2]	Prone	8·8	<0·01
Carpenter[6]	Not supine	2·62	<0·01
Froggatt[4]	Not supine	4·21	<0·01

The well recognised effects of elevated environmental temperature on respiratory patterns in infants were mentioned and then summarily dismissed by Drs Gunteroth and Spiers. The potential role of such effects in the sudden infant death syndrome at least deserve further examination.

Though we welcome serious scientific discussion of the implications of our research, it seems more appropriate to examine carefully the basis of popular ideas on infant care rather than to discount potentially important observations because they do not conform to cherished dogma.

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1 Gunteroth WG, Spiers PS. Bedding and sleeping position in the sudden infant death syndrome. *BMJ* 1990;**301**:494. (8 September.)
2 Fleming PJ, Gilbert R, Azar Y, *et al*. Interaction between bedding and sleeping position in the sudden infant death syndrome: a population based case-control study. *BMJ* 1990;**301**:85-9. (14 July.)
3 Lee NNY, Chan YF, Davies DP, Lau E, Yip DCP. Sudden infant death syndrome in Hong Kong: confirmation of low incidence. *BMJ* 1989;**298**:721.
4 Froggatt P. In: Bergman AR, Beckwith JB, Ray CG, eds. *Sudden infant death syndrome*. Seattle: University of Washington Press, 1970:40.
5 Gardner MJ, Altman DG. *Statistics with confidence*. London: British Medical Journal, 1989.
6 Beal SM. Sleeping position and SIDS. *Lancet* 1988;ii:512.
7 Jonge CA, Engelberts AC, Koomen-Liefting AJM, Kostense PJ. Cot death and prone sleeping position in The Netherlands. *BMJ* 1989;**298**:722.

SIR,—Having had personal experience of this tragedy, I believe that I am in a position to criticise